IdealCare Silver 73 / $15 PCP / $10 Gen Rx / Free Telemed.

Medical-Surgical and Behavioral Health/Substance Abuse Disorder Schedule of Coverage

The following information summarizes the benefits described in your Evidence of Coverage. It is important that you carefully read it so you are aware of plan requirements, provisions, limitations and exclusions.

This Schedule of Coverage is not a Medicare Supplement. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

Note: This Consumer Choice Health Benefit Plan does not include all state mandated health insurance benefits. Some benefits are provided at a reduced level from what is mandated. Reduced benefits are indicated in the chart below and in the separate Benefit Disclosure Form.

Overall Payment Provisions	**In-Network Benefits**	**Out-of-Network Benefits**	**Indian Health Care Provider (IHCP) (You will pay the least)**
Calendar Year Deductibles (applies to all Eligible Expenses including Pharmacy)	$4,000.00 Individual / $8,000.00 Family (Out-of-Network Services are Excluded unless they are approved by the Plan or are Emergency Services)		$0 Individual/$0 Family
Out-of-Pocket Limits (applies to all Eligible Expenses including Pharmacy	$6,800.00 Individual / $13,600.00 Family (Out-of-Network Services are Excluded unless they are approved by the Plan or are Emergency Services)		$0 Individual/$0 Family
Maximum Lifetime Benefits – per participant	Unlimited (Out-of-Network Services are Excluded unless they are approved by the Plan or are Emergency Services)		
Primary Care Visit to Treat an injury or illness	100% of Allowed Amount after a $15.00 Copayment per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Specialist office visit/consultation	100% of Allowed Amount after a $50.00 Copayment after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Other Practitioner Office Visit (Nurse, Physician Assistant)	100% of Allowed Amount after a $15.00 Copayment per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Outpatient Facility fee (e.g.., Ambulatory Surgery Center)	10% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Outpatient Surgery Physician/Surgical services	10% of Allowable Amount after	No coverage for Out-of-Network Services	100% of Allowed Amount

	Calendar Year Deductible		
Hospice	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Urgent Care Centers or Facilities	100% of Allowed Amount after a $50.00 Copayment per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Home Health Care Services Limited to 60 visits per year.	100% of Allowed Amount	No coverage for Out-of-Network Services	100% of Allowed Amount
Emergency Room Services	100% of Allowed Amount after a $350.00 Copayment after Calendar Year Deductible per Visit	100% of Allowed Amount after a $350.00 Copayment after Calendar Year Deductible per Visit	100% of Allowed Amount
Emergency Medical Transportation/Ambulance	100% of Allowed Amount after a $350.00 Copayment after Calendar Year Deductible per Transportation	100% of Allowed Amount after a $350.00 Copayment after Calendar Year Deductible per Transportation	100% of Allowed Amount
Inpatient Hospital Services (Hospital Stay) – All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	100% of Allowed Amount after a $350.00 Copayment after Calendar Year Deductible per Stay	No coverage for Out-of-Network Services	100% of Allowed Amount
Inpatient Physician and Surgical Services	30% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Skilled Nursing Facility Limited to 25 visits per year.	100% of Allowed Amount after a $300.00 Copayment after Calendar Year Deductible per Stay	No coverage for Out-of-Network Services	100% of Allowed Amount
Prenatal and Postnatal Care	100% of Allowed Amount after a $10.00 Copayment for the initial Prenatal Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Childbirth/Delivery Professional Services	30% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount

Delivery and All Inpatient Services for Maternity Care	100% of Allowed Amount after a $350.00 Copayment after Calendar Year Deductible per Delivery	No coverage for Out-of-Network Services	100% of Allowed Amount
Mental/Behavioral Health Care Outpatient Services*	25% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Mental/Behavioral Health Care Inpatient Hospital Services*	100% of Allowed Amount after a $350.00 Copayment after Calendar Year Deductible per Stay	No coverage for Out-of-Network Services	100% of Allowed Amount
Substance Abuse Disorder Outpatient Services*	25% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Substance Abuse Disorder Inpatient Services*	100% of Allowed Amount after a $350.00 Copayment after Calendar Year Deductible per Stay	No coverage for Out-of-Network Services	100% of Allowed Amount
Outpatient Rehabilitation	100% of Allowed Amount after a $65.00 Copayment after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Habilitation Services	25% of Allowable Amount after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Chiropractic Services Limited to 35 visits per year	100% of Allowed Amount after a $60.00 Copayment after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Durable Medical Equipment	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Hearing Aids for Adults (1 per ear every 3 years)	20% of Allowable Amount after Calendar Year Deductible per Hearing Aid	No coverage for Out-of-Network Services	100% of Allowed Amount
Hearing Aid or Cochlear Implant, related services and supplies, if medically	20% of Allowable Amount after Calendar Year	No coverage for Out-of-Network Services	100% of Allowed Amount

necessary for all covered individuals including individuals who are 18 years of age or younger. Please contact Sendero Customer Service Department at 1-844-800-4693 to obtain the cost of hearing aid or cochlear implant.	Deductible per Hearing Aid or Cochlear Implant		
Imaging (CT/PET scans, MRIs)	25% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Preventative Care/Screening/Immunization	100% of Allowed Amount	No coverage for Out-of-Network Services	100% of Allowed Amount
Annual Well Woman Exam – including cervical cancer and ovarian cancer screening (age 18 and over)	100% of Allowed Amount	No coverage for Out-of-Network Services	100% of Allowed Amount
Annual screening by low-dose mammography for the presence of occult breast cancer for female participants age 35 and over – Outpatient facility or imaging center and Physician component	100% of Allowed Amount	No coverage for Out-of-Network Services	100% of Allowed Amount
Bone Mass measurement for the detection of low bone mass to determine risk of osteoporosis and fractures associated with osteoporosis for qualified individuals	100% of Allowed Amount	No coverage for Out-of-Network Services	100% of Allowed Amount
Routine annual prostate cancer detection exam, including a Prostate Specific Antigen test (PSA) for a male Covered Person age 40 or older.	100% of Allowed Amount	No coverage for Out-of-Network Services	100% of Allowed Amount
Routine Foot Care	100% of Allowed Amount after a $40.00 Copayment per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Routine Eye Exam for Children (1 per year)	100% of Allowed Amount after a $40.00 Copayment per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Eye Glasses for Children (1 set of frames with lenses or contact lenses per year)	20% of Allowable Amount after	No coverage for Out-of-Network Services	100% of Allowed Amount

	Calendar Year Deductible		
Dental Check-Up for Children	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Rehabilitative Speech Therapy	100% of Allowed Amount after a $60.00 Copayment after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Rehabilitative Occupational and Rehabilitative Physical Therapy	100% of Allowed Amount after a $60.00 Copayment after Calendar Year Deductible per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Well Baby Visits and Care	100% of Allowed Amount	No coverage for Out-of-Network Services	100% of Allowed Amount
Laboratory Outpatient and Professional Services	25% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
The administration of whole blood including cost of blood, blood plasma, and blood plasma expanders are covered services	25% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
X-rays and Diagnostic Imaging	100% of Allowed Amount after a $30.00 Copayment after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Basic Dental-Children	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Orthodontia-Children	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Major Dental Care- Children	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Transplant	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount

Accidental Dental	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Dialysis	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Allergy Testing	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Chemotherapy	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Radiation	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Diabetes Education	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Prosthetic Devices	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Infusion Therapy	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Treatment for Temporomandibular Joint Disorders	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Nutritional Counseling	100% of Allowed Amount after a $5.00 Copayment per Visit	No coverage for Out-of-Network Services	100% of Allowed Amount
Reconstructive Surgery	20% of Allowable Amount	No coverage for Out-of-Network Services	100% of Allowed Amount
Mammography	100% of Allowed Amount after a $250.00 Copayment per Visit after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount

Cardiovascular Disease	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Osteoporosis	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Diabetes Care Management	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Inherited Metabolic Disorder (PKU)	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Post-Mastectomy Care	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Brain Injury	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Transplant Donor Coverage	20% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount
Autism Spectrum Disorders	25% of Allowable Amount after Calendar Year Deductible	No coverage for Out-of-Network Services	100% of Allowed Amount

*Sendero Health Plans (Sendero) will provide benefits and coverage for mental health conditions and substance use disorders under the same terms and conditions applicable to the plan's medical and surgical benefits and coverage. Sendero may not impose quantitative or non-quantitative treatment limitations on benefits for a mental health condition or substance use disorder that are generally more restrictive than quantitative or non-quantitative treatment limitations imposed on coverage of benefits for medical or surgical expenses.